

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=63-021184

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No. 306 Primary Registration District No. 6048 Registrar's No. 38

FILED JUN 3 1963

1. PLACE OF DEATH a. COUNTY <u>St. Charles</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo</u> b. COUNTY <u>St. Charles</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Dardenne</u>		c. CITY OR TOWN <u>O'Fallon</u>	
Length of stay in 1b <u>15 yrs</u>		Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>206 Hwy. 175</u>		d. STREET ADDRESS (If outside, give location) <u>206 Hwy. 175</u>	
Inside Limits Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) <u>Catherine Elizabeth Schroeder</u>			4. DATE OF DEATH Month <u>May</u> Day <u>26</u> Year <u>1963</u>		
5. SEX <u>female</u>	6. COLOR OR RACE <u>Cau</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>9-4-1885</u>	9. AGE (last birthday) <u>77</u>	IF UNDER 1 YEAR IF UNDER 24 HR. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home Duties</u>		11. BIRTHPLACE (City and state or country) <u>St. Charles, Mo</u>	
12. CITIZEN OF WHAT COUNTRY <u>USA</u>		13a. FATHER'S NAME <u>Fritz Knoop</u>		13b. MOTHER'S MAIDEN NAME <u>Koch</u>	
14. NAME OF HUSBAND OR WIFE <u>Charles H. Schroeder</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>[redacted]</u>	
17. INFORMANT <u>Elsie Schroeder O'Fallon, Mo</u>		Address			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis</u>		DUE TO (c) <u>Senility and Dishevel</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u>[redacted]</u> a.m. <u>[redacted]</u> p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>O'Fallon, Mo</u>		
21. I attended the deceased from <u>May 25, 1963</u> and last saw him alive on <u>May 25, 1963</u> Death occurred at <u>3:30</u> <u>A</u> m. on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <u>5/28/63</u>	
22a. SIGNATURE (Degree or title) <u>Donald G. Knoop DO</u>		22b. ADDRESS <u>O'Fallon, Mo</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE <u>May 29, 1963</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>	23d. LOCATION (City, town, or county) <u>St. Charles, Mo</u>
24. FUNERAL DIRECTOR <u>Keithly-Davis Chapel</u>		25. DATE RECD. BY LOCAL REG. <u>5-28-63</u>	26. REGISTRAR'S SIGNATURE <u>Task Keithly</u>

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

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Rev. 4/59

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FILED JUN 1 1963

JUN 1 2 1963

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Jerry A. Davis

Licensed Embalmer No. 5139

P. O. Address O Fallon, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.